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A Case of Hypopyon Kerato-Iritis Occurring in a Patient During an Attack of Typhoid Fever

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PHILADELPHIA

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A CASE OF HYPOPYON KERATO-IRITIS OCCURRING IN A PATIENT DURING AN ATTACK OF TYPHOID FEVER.*

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In a recent paper by Charles Stedman Bull of New York concerning the ocular complications of typhoid fever, the statement is made that the order of frequency with which these complications occur is as follows: Conjunctivitis of the catarrhal type, phlyctenular conjunctivitis and keratitis, loss of accommodation and dilatation of the pupil, retinal hemorrhages of various kinds, paralyses of the external ocular muscles, neuro-retinitis or retro-bulbar neuritis and inflammations of the uveal tract. Among the latter, or most infrequent complications, belongs the following case:

K. S., aged 53 years, a widow, had been ill for three weeks with typhoid fever, complicated with catarrhal pneumonia and jaundice, when I was requested by her physician to make an examination of her eyes. The right eye had been inflamed for two weeks, during which time there had been constant severe pain in the eye itself and throughout the right side of the head, extending to the occiput. The dread of light had also been very marked, and these two symptoms had been partially relieved by daily hypodermatic injections of morphine and by keeping the room darkened. The patient had recovered from the pneumonia, the jaundice had almost disappeared, and the typhoid fever was abating, it being the beginning of the fourth week of the disease.

Examination of the eyes showed a marked serous iritis in the right eye with annular synechiæ, pupil 2mm. in diameter and dilating but little after repeated instillations of scopalamin and cocain. The visual acuity equaled the counting of fingers at 2 meters. There was slight hypopyon. No view of the fundus could be obtained. In the upper inner quadrant of the cornea at the corneo-scleral junction, there was an ulcer about 4mm. long and 2mm. broad. Between this and the center of the cornea there were several spots of infiltration (probably abscesses). The treatment advised consisted of hot compresses to be employed for 30 minutes every two hours, leeches to the temple, thorough cleansing with a saturated boric acid lotion every two hours, and the instillation of one drop of a solution of atropin sulphat (gr. iv–ʒ i) every four hours.

*Read before the Philadelphia County Medical Society, February 9, 1898.

One week later I was requested to see the patient again, when the pupil was found to be widely dilated, except a small synechia below. There were numerous pigment spots on the lens-capsule and a number of opaque spots on the posterior surface of the cornea. These latter were not the spots ordinarily seen in serous iritis, but much larger and much more opaque, it being impossible to distinguish whether they were deposits of lymph or thickened pus. There was marked pericorneal injection, intense pain and shrinking upon making the least pressure through the closed lids, and in the corneal substance were found several opaque spots (not yet ulcers) occupying not only the upper and inner quadrant, but also the lower and outer quadrant. The ulcer was a trifle larger than when first seen, the amount of pus in the anterior chamber remaining about the same. The administration of quinin was added to the treatment advised at the previous examination.

Four days later the ulcer was so much larger and the hypopyon so much greater that all portions of the former were cauterized with the actual cautery, and the hourly cleansing with a solution of formaldehyde (1-2000) was suggested. A note from the attending physician received nearly a week after the operation stated that there had been no pain since the application of the cautery, and that the opaque spots were disappearing from the cornea. The hypopyon had also disappeared.

In less than a week from the reception of the note the patient was brought to my office. The visual acuity of the right eye equaled 5/30; of the left, 5/6. The eye was quiet, and the ulcerative process had been checked. There remained a small synechia below. Massage with yellow oxid of mercury ointment, in which atropin had been incorporated, was now employed to clear the corneal opacity.

Two and a half weeks later there was a recurrence of the ulceration near the original place in the upper and inner quadrant, which soon subsided, however, from the use of atropin and frequent cleansings with the solution of formaldehyde.

Ten days later the eye was quiet and the ulcer healed. One month later the vision in each eye equaled 5/6, that of the left being 5/5 with a correcting glass, while that of the right could not be improved. There were no lesions of the eye-grounds.

The case, though an isolated one, is recorded, first, because of the infrequency of its occurrence, and second, because it serves to remind us that in all cases of disease when the vital forces are markedly impaired, or when there is a possibility of an embolic process taking place, the condition of the eyes should be carefully watched.

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